SECTION 2

HOME HEALTH AGENCIES

Table of Contents

1 GENERAL POLICY

Home Health services are a benefit of the Utah Medicaid Program as described in this Section. Home health services are medically necessary, part-time, intermittent health care services provided to eligible persons in their place of residence when the home is the most appropriate and cost effective setting consistent with the client's medical need, and when the medical need can be safely met in the home through one of two nursing skill levels with support from family care givers.

Home Health Agencies requesting services should encourage and identify how much help is available from the family to supplement the agency assistance. There is no age limitation for home health care. Support and assistance from family members is essential in order to maintain home health service for some clients at a level that is realistically appropriate and cost effective. Family members who have physical and/or medical limitations which could affect their ability to participate in supplementing agency services can provide a statement from their primary care physician identifying the limitations. The medical statement(s) will be considered in the evaluation of care needs.

Home health services must be based on a physician's order and a plan of care. The home health care provided must require the skills of technical or professional personnel such as a registered nurse (R.N.), licensed practical nurse (L.P.N.), trained home health aide, physical therapist, or speech pathologist. Service is limited to one visit per day.

The goals of home health care are to minimize the effects of disability or pain; promote, maintain or protect health; and prevent premature or inappropriate institutionalization while allowing the patient to live at home in personal dignity and independence. The home health agency should effectively coordinate all patient care services to meet the medical, nursing and related health needs of the patient in the home.

Two levels of nursing care are provided through home health with support from family care givers:

First, a highly skilled level of care where the severity of illness and intensity of service are such that the attendance of a family or professional care giver is necessary on a consistent basis; specialized equipment is required to support activities of daily living; and the ability to function outside of the home is severely limited by medical needs, treatment, supportive equipment and the need for physical assistance.

Second, a supportive maintenance level of care where the patient demonstrates permanent limitations or significant disability due to illness or injury, requiring minimal assistance, use of specialized equipment, assistance with activities of daily living, observation, teaching and follow-up. Care needs are relatively stable, supportive in nature, and long term. The client is capable of leaving home to attend school, sheltered workshops, work, or receive necessary medical care after assistance from the care giver to get out of bed, bathe, dress and get into a wheelchair or other conveyance. Assistance may be needed to reverse the process at night. Specialized transportation is required for the patient to travel outside of the home — handicap bus or van, or taxi. If the patient drives himself or demonstrates the ability to move about independently, the medical need and home health service should be in question. The typical client requiring this level of service is generally the paraplegic or quadriplegic individual. However, this level of care can also apply to clients with medical needs related to degenerative neurological diseases; newly diagnosed diabetics; acute, high risk diabetic complications; and those with multi-system problems requiring a skilled service or acute monitoring.

All home health service must be supervised by a registered nurse employed by an approved, certified home health agency. Nursing service and all approved therapy services must be provided by the appropriate licensed professional.

Legal References: Sections 1102, 1842, 1861, 1862, 1870 and 1871 of the Social Security Act; 42 Code of Federal Regulations, Part 484 and 440.70.

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed care plan, such as a health maintenance organization (HMO) or Prepaid Mental Health Plan (PMHP), must receive all health care services, including medical supplies, through that plan. Refer to SECTION 1, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1,Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs and PMHPs with which Medicaid has a contract to provide health care services is included as an attachment to the provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to what plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Billing

Home health services may be billed electronically or on paper, using the CMS-1500 claim format. Use the procedure codes listed in Chapter 6. Billing methods are covered in SECTION 1 of this manual, Chapter 11 - 9. Medicaid encourages electronic billing. Mistakes can be corrected immediately, and your claim is processed without delays. Electronic claims may be submitted until noon on Friday for processing that week.

Providers who use the paper claim form should contact the Utah Health Information Network (UHIN) for standard instructions. Providers can call (801) 466-7705.

1 - 4 Definitions

Home Health Agency

Home health agency means a public agency or private organization which

A. Is primarily engaged in providing skilled nursing service and other therapeutic services;

B. Has policies established by a group of professional personnel (associated with the agency or organization) including one or more physicians and one or more registered professional nurses, to govern the services which it provides, and provides for supervision of such services by a physician or registered professional nurse;

C. Maintains clinical records on all patients;

D. Meets licensing standards established for home health agencies by state and local law;

E. Is state licensed, Medicare certified, enrolled as a Medicaid provider and has in effect an overall plan and budget that meet specified requirements;

F. Meets other such conditions of participation as the Secretary of Health and Human Services may find necessary in the interest of the health and safety of individual who are provided home health services.

G. Meets surety bond requirements for Home Health agencies (HHA) as specified by the Health Care Financing Administration (HCFA). Reference: Title 42, Code of Federal Regulations (42 CFR), Section 441.16. Following is a summary of the bond requirements.

A Home Health agency (HHA) providing Medicaid services must provide a surety bond issued by an approved surety agency and effective for services provided on or after January 1, 1998, to the Utah Department of Health, Division of Health Care Financing. Although Medicaid is required to follow the Medicare requirements for surety bonds, a separate bond must be provided to Medicaid. The bond must name the HHA as the principal; the State of Utah, Department of Health, as the obligee (the beneficiary of the bond); and the surety as Surety. It must contain a clause requiring the surety agency to notify the State in the event of cancellation.

The amount of the bond must be a minimum of $50,000 or 15% of the annualized Medicaid expenditures to the HHA, whichever amount is greater. However, if a HHA has historical overpayments that exceed 15% of its total expenditures, the State may require a bond greater than 15%.

Included with this manual is the Surety Bond Form which, when properly completed, will be accepted by Medicaid as proof of compliance with the surety bond requirements.

H. A Home Health agency applying to become a Medicaid provider must meet new Financial Viability and Capitalization requirements, as stated in the Federal Regulations. The HHA must have at least three months of operating capital initially available and provide documentation that at least 50% of these funds are “the HHA’s own, non-borrowed funds which are not in any way encumbered.”

Home Health Agency Visit

A visit is a personal contact in the place of residence of a patient for providing a covered service by appropriate personnel under the supervision of a home health agency. Up to two (2) hours of care constitutes one visit. A visit is usually not less than one hour. The average visit for skilled care is one hour. Visits by personnel other than those providing covered services are not home health visits.

Home Health Aide Services

Home health aide services are those provided by a person selected and trained to assist with routine care not requiring specialized nursing skill. The aide is closely supervised by a registered nurse to assure competent care. The aide works under written instructions for care to be provided.

Home Health Assessment Visit

A visit made by a registered nurse initially or at recertification to assess the patient's overall condition; to determine the adaptability of the patient's place of residence to the provision of health care and the capability of the patient to participate in his own care; and to identify family support systems or individuals willing to assume responsibility for care when the patient is unable to do so.

The outcome of the assessment visit is a documented plan of care based on the physician's written orders and the registered nurse's assessment.

Licensed Practical Nurse (L.P.N.)

A licensed practical nurse provides care and service for patients whose care needs are stabilized. The L.P.N. functions in accordance with agency policy as a member of the nursing team working directly under the supervision of a registered nurse. An L.P.N. may prepare clinical and progress notes, assist the physician and/or registered nurse to perform specialized procedures, prepare equipment and materials for treatments, observe aseptic technique as required, and assist the patient to learn appropriate self-care techniques.

PRN Nurse Visit

A PRN visit is an 'emergency visit' by a registered nurse to a patient receiving skilled nursing service. The visit may be requested by the patient or a family member in response to a change in condition. PRN visits can only be provided and billed by a registered nurse. Visits are limited to no more than two in a thirty (30) day period. The emergency situation must be documented.

Skilled nursing service

Skilled nursing service is the expert application of nursing theory, standardized procedures and medically delegated techniques by a registered nurse (R.N.) to meet the needs of a patient in his residence, using professional judgment to independently solve patient care problems.

Support from family care givers

The act or an instance when a member of the family provides help or assistance to another family member who has permanent limitations or significant disability due to illness or injury. Support may be indirect such as visiting, shopping, running errands, doing laundry, preparing a meal. Support may also be direct hands on physical care within the ability of nonprofessionals to meet medical needs or support activities of daily living. Such support is not reimbursable to family members.

Supervision

Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction, the physical presence of the supervisor until the trainee is considered competent, and periodic inspection of the actual act of accomplishing the function or activity. A supervision visit is considered an administrative expense for the agency, rather than a reimbursable expense.

Supportive maintenance home health

A level of service which requires minimal assistance, observation, teaching or follow-up, such as ambulation and exercise, limited household services essential to health care at home, reminders about medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.

2 LIMITATIONS

The following limits apply to coverage of home health services.

A. Home health service must be cost effective. That is, it must cost less over the long-term to provide the required care and service in the patient's home than it would cost to meet the medical needs in a nursing facility or other institutional setting.

B. Home health care must be based on orders written by a physician and documented in a plan of care which is part of the patient's medical records and maintained in the home health agency providing care.

C. After the initial assessment visit, all home health care requires prior authorization.

D. Medical supplies furnished by the home health agency are limited to those used during the initial visit to establish the plan of care.

E. Home health care is limited to one visit per day, except in limited circumstances as outlined in the code table, Chapter 7, HOME HEALTH PROCEDURE CODES. A Plan of Care which exceeds established limits will not be approved.

F. An R.N./L.P.N. may bill for a brief visit to provide a skilled service the aide cannot provide, the same day as the home health aide visits. The services must be appropriately prior authorized.

G. An aide may visit only once a day, unless billing for an extended level of service, (S9122); extended level of service visits are limited to two a day.

H. Personal care aides and home health aides cannot be reimbursed for visits the same day.

I. Reimbursement is subject to all other limits as indicated in the code table in Chapter 7, HOME HEALTH PROCEDURE CODES

J. A comprehensive level of service visit by an R.N. is limited to one in a 60-day period.

K. A PRN visit by an R.N. is limited to two in a 30-day period.

L. An acute skilled nursing care visit by an R.N. is limited to twice a day for a maximum of 21 visits. It is limited to the first month of service unless the client reverts to an acute phase of a chronic condition.

M. Speech and physical therapy visits are limited to the most appropriate cost effective place of service. The home setting can not be chosen for the convenience of the therapist or family, especially if the patient is otherwise able to leave the home for other outpatient service and does leave to attend school.

N. Medicaid restricts hemophilia blood factors to a single provider. The purpose is to provide a uniform hemophilia case management support program to the patient and patient's physician and to achieve economies in the purchase of blood factor through a sole source contract. Medicaid will reimburse only the sole source provider for hemophilia case management, blood factors VII, VIII and IX. No other provider will be paid for blood factors VII, VIII or IX supplied. Medicaid clients who choose not to participate in the Medicaid Hemophilia program must make their own arrangements for procurement and payment of the blood factor.

   The contract affects only the procurement and management of the prescribed blood factor. The patient's physician continues to be responsible to develop a plan of care and to prescribe the blood factor. The contract with the sole source provider specifies the provider must work closely with the patient's Primary Care Provider physician or managed care plan.

   As of October 2000, the sole source provider is University Hospital Home Infusion Services. Please direct questions concerning hemophilia case management and blood factors VII, VIII and IX to this provider: 801 - 466-7016.

   Managed care plans which contract with Medicaid continue to be responsible for hemophilia-related services such as physical therapy, lab work, unrelated nursing care, and physician services.

3 NON COVERED SERVICES

Medicaid does not cover home health services in the following situations:

1. Home health care provided to a patient capable of self care is not covered.

2. Home health care provided to a patient residing in a hospital, skilled nursing facility or intermediate care facility is not covered.

3. Personal care services, except as determined necessary in providing skilled care, are not covered.

4. Housekeeping or homemaking services are not covered.

5. Occupational therapy is not covered.

6. Respite care is not covered.

7. Care for social needs is not covered.

8. A visit to supervise a home health employee is not reimbursable as home health care. A supervision visit is considered an administrative expense for the agency.

9. Medical supplies are not covered by the home health agency program, except as indicated in Chapter 4 - **3**, Skilled Nursing Service, subpart C.

10. Palliative or maintenance care for speech and physical therapy is not a covered benefit. A minimal amount of time may be approved in unusual circumstances of medical necessity, to be determined by the Medicaid nurse reviewer, to check compliance with a home therapy program established by a therapist for the patient to follow. Routine approval for palliative or maintenance visits will not be given and should not be expected.

11. Only one home health provider (Agency) will be approved to provide services to a patient during any period of time. A second provider or agency requesting approval of service will be denied.

4 COVERED SERVICES

Home health services are covered only when provided to a patient who is under the care of a physician and has an approved plan of care. This physician may be the patient's private physician, a physician on the staff of the home health agency or, if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician writes the orders on which a plan of care is established, certifies the necessity for home health services, and supervises the care. Services must be based on medical necessity. After the initial visit, all home health care services require prior authorization. Home health care must be furnished directly by or under the supervision of a registered nurse.

Home health services are:

- Skilled nursing service which includes
  - Nursing Care (R.N. or L.P.N.)
  - Speech therapy
  - Physical therapy
  - Medical supplies
  - I.V. therapy

- Supportive maintenance services

- Long term services under the capitated care option.

Criteria for each service are described in the remainder of this chapter. Procedure codes for home health services are listed at the end of this section.

4 - 1 Selection Criteria

When reviewing requests for home health service, the emphasis is on medical necessity, severity of illness and intensity of service. When a request for home health service is received, Medicaid Prior Authorization staff will use the criteria listed below to evaluate the home setting for appropriateness and safety.

- Diagnosis, condition and prognosis
- Reason for the request
- Goals for home health service? Short or long term?
- Physician orders, care plan, anticipated length of service
- Equipment and supplies needed: oxygen, I.V.'s, assistive devices, etc.
- Mobility and ability for self care, immediate and long term
- Self care teaching needs
- Limitations: physical or environmental related to the disease process, and whether temporary or permanent
- Potential for improvement of condition and eliminating need for service
- Whether service can be appropriately and safely provided in the home
- Whether there is a more appropriate, less costly alternative for care
- Whether other alternatives to home care service by an agency have been considered or ruled out
- Whether other alternatives have been explored: rehabilitation, long term care
- Who are the family and/or professional care givers? Are they knowledgeable, committed, supportive, willing to learn? What teaching needs are apparent?

4 - 2 Plan of Care

The Plan of Care is a written plan developed cooperatively by the home health agency staff and the patient's attending physician. The plan must be designed for the agency to adequately meet specific needs of the patient in the patient's place of residence, be based on orders written by the physician, and be signed by the physician. The approved plan must be incorporated in the agency's permanent record for the patient.

A. Plan of Care Requirements

The plan of care developed in consultation with the agency staff must cover the following:

1. Diagnoses
2. Mental status
3. Types of service
4. Medical equipment and supplies required
5. Frequency of visits
6. Rehabilitation potential
7. Functional limitations
8. Activities permitted
9. Nutritional requirements
10. Medications
11. Treatments and therapies
12. Discharge planning or referral
13. Other identified appropriate services

B. Periodic Review of Plan of Care

At least every sixty (60) days, the patient's physician must review and recertify the need for continuing home health care. The current Plan of Care must be reviewed by the attending physician, in consultation with agency professional personnel, at such intervals as the severity of the patient's illness requires and at least every 60 days. Medicaid must approve an updated Plan of Care at least every sixty days.

The average home health patient is served for 60-75 days. As the sixty-day time frame nears, the home health agency should determine the need for continued care and complete a new prior authorization request. Include all information and documentation as was initially required.

C. Conformance with Plan of Care

Drugs and treatments must be administered by agency staff only as ordered by a physician and approved in the Plan of Care.

D. Changes in Plan of Care

All changes shall be made in writing and signed by the physician or by a registered nurse on the staff of the agency receiving the physician's oral order. All oral orders must be subsequently documented in writing on or before the next plan review. All changes in orders for legend drugs and narcotics must be signed by the physician.

If the patient does not require home health care for the entire sixty day period, service should be discontinued as appropriate.

4 - 3 Skilled Nursing Service

Nursing services, as defined in the Utah Nurse Practice Act, are covered when provided on a part-time basis by a home health agency. Part-time or intermittent services are usually services for a few hours a day several times a week. Occasionally, more services may be provided for a limited time when recommended by a physician and included in the approved plan of care. Skilled nursing service is the expert application of nursing theory, standardized procedures and medically delegated techniques by a registered nurse (R.N.) to meet the needs of a patient in his or her residence, using professional judgments to independently solve patient care problems. A home health aide may provide certain skilled nursing services under the supervision of a registered nurse and in accordance with the plan of care.

The registered nurse makes the initial assessment and recertification visits, regularly reevaluates the patient's nursing needs, initiates the plan of care, makes necessary revisions, provides services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nursing and related needs, participates in in-service programs, and supervises and teaches other nursing personnel.

A. Assessment Visits

An in-depth physical and psychosocial assessment must be made by a registered nurse initially or at recertification to assess the patient's overall condition, needs, adaptability of the patient's place of residence to the provision of health care, capability of the patient to participate in his or her own care, identify family support systems or persons willing to assume responsibility for care when the patient is unable, and establish a plan for delivery of care.

The home health agency may conduct an initial assessment visit on the reasonable expectation that a patient's needs can be met adequately in the place of residence by the agency. An initial assessment visit does not require prior authorization.

The outcome of the assessment visit is a documented plan of care based on the physician's written orders and the registered nurse's assessment.

The initial plan of care and all necessary information for approval of service is expected to be submitted within three working days from the date of the initial request for home health service. Without timely review, approval may not be given.

The recertification visit must be completed every 60 days. (See SECTION 2, page 11 #B). The new information must be sent at least three days before expiration of the first approval and the end of the first episode of care. A new time study must be submitted with each recertification request. Services provided without continuing authorization may not be approved.

Bill the initial visit and each recertification assessment using code T1001.

As indicated on the Home Health Procedures Table, the home health aide code S9122 cannot be billed on the same date of service as T1001, Initial assessment/recertification assessment.

B. Speech-Language Services through Home Health

Speech-Language services are covered services under Home Health when the home is the most appropriate and cost effective place for the service. Speech-Language services must be medically necessary and essential to treat problems associated with birth defects, prematurity, illness, accidents or injury. All services must be provided under physician orders, in accordance with a Plan of Care, and provided by a licensed, qualified Speech-Language therapist employed directly by or on contract to a Home Health Agency. There must be an expectation that with treatment, the patient's medical condition will improve in a predictable period of time. It is expected that goals and objectives for a particular patient would initially be met in the home by 12-16 visits or fewer based on diagnosis. Outpatient service must be considered for any continuing service beyond the initial intervention when the patient participates in other activities outside the home.

Before any therapy services are provided in the home, the Home Health Agency must request prior authorization. The speech-language services must be approved as part of the complete Plan of Care. The prior authorization request must include, but is not limited to:

- A plan of care based on physician orders
- Current medical findings and diagnosis
- Identification of any previous treatment provided
- Anticipated goals and methods of treatment clearly stated
- Amount, duration and frequency of services
- Prognosis

The plan of care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified with physician involvement every 6 months. Requests for continued service in the home will by evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

- A medical evaluation from the physician including any change in medical condition and prognosis
- A status/progress report from the speech-language therapist clearly stating progress made toward meeting previous goals. Continued service is questionable if there is no progress. The speech-language therapist is responsible to recommend discontinuation of treatment when continued progress is not evident
- Goals, objectives, treatment methods and frequency of continued service requested. Goals must include teaching family care givers to work with the patient on a daily basis so that improvement can be maintained.
- Medical problems the patient may have that support or justify continued service in the home
- Anticipated transition to outpatient service
- If the patient is on the Tech Dependent Waiver or Early Intervention Programs, the information must be included with each request.

Speech Language Services are non-covered for the following:

- Social, educational or developmental limitations without medical diagnosis
- Chronic conditions which cannot benefit from communication services or where there is no potential for improvement
- Non-therapeutic routine, repetitive or reinforcing procedures

C. Physical Therapy Services in the Home

Physical Therapy services are covered services through Home Health when the home is the most appropriate and cost effective place for the service to be provided. Physical therapy services must be medically necessary and essential to treat problems associated with accidents, injury, illness, birth defects or prematurity. All physical therapy must be provided under physician orders, in accordance with a Plan of Care, and provided by a licensed, qualified physical therapist employed directly by or on contract to a Home Health Agency. There must be an expectation that with treatment, the patient's medical condition will improve in a predictable period of time. It is expected that goals and objectives for a particular patient would initially be met in the home by 12 - 16 or fewer visits based on the diagnosis. Outpatient service must be considered for any continuing service beyond the initial intervention when the patient participates in other activities outside the home.

The purpose of physical therapy in the home is to improve the functional ability of a patient with a temporary or permanent disability.

The goal of physical therapy in the home is to improve the ability of the patient, through the rehabilitative process, to function at a maximum level.

Before any physical therapy is provided in the home, including an evaluation, a prior authorization for service must be requested by the Home Health Agency. The physical therapy services must be approved as part of the complete Plan of Care. The prior authorization request must include, but is not limited to:

- A Plan of Care based on physician orders for medically necessary services to be provided
- Patient information, history, current medical findings, diagnosis and severity of the medically oriented disorder or disability
- A factual evaluation and statement of the function present and prognosis for reasonable and predictable improvement.
- Expected goals and objectives for the patient that may reasonably be achieved in a predictable period of time using professionally appropriate standards.
- The specific treatments or modalities to be used, frequency of treatment sessions, and anticipated duration of the physical therapy service

The Plan of Care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified with physician involvement every 6 months. Requests for continued service will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

- A medical evaluation from the physician including any change in medical condition and prognosis
- A status/progress report from the physical therapist clearly stating progress made toward meeting previous goals. Continued service is questionable if there is no progress
- Physician orders, goals objectives, treatment methods and frequency of continued service requested.. Goals must include teaching family care givers to work with the patient on a daily basis so that improvement can be maintained.
- Medical problems the patient may have that support or justify continued service in the home
- Anticipated transition to outpatient service
- If the patient is in the Tech Dependent Waiver or Early Intervention Programs, the information must be included with the request.

Physical Therapy services are non-covered for the following:

- Social or educational limitations without medical diagnosis
- Conditions where there is no documented potential for improvement
- Non-therapeutic repetitive or reinforcing procedures

D. Occupational Therapy through home health is not a covered service except under the CHEC program for children. Requests for service must be made through the Utilization Management nurse reviewers with subsequent review by the CHEC Committee for a determination of coverage. Information for review must be based on physician orders, a plan of care, and clear indication of medical necessity. Occupational therapy in the home is not an option for convenience of physician, family or therapist. If the child is able to leave the home for school, medical appointments, or any other activities, therapy in an outpatient setting must be the first consideration for coverage. In order to adequately review requests in a timely manner, complete, detailed information should accompany the request.

Information to be provided for review includes, but is not limited to:

- A plan of care based on physician order
- Diagnosis and associated medical problems.
- Goals of therapy clearly stated. There must be an expectation that with treatment the patient's medical condition will improve in a predictable period of time.
- If requesting recertification, documentation must clearly show child has met previous goals, made measurable improvement and is moving on and progressing to new goals. Continued service is questionable if there is no progress.
  Goals must include teaching family care givers to work with the child on a daily basis so that improvements can be maintained.
- What medical problems does the child have that would support or justify home bound status? Explain.
- If immunosuppression is mentioned, why is the child immunosuppressed? What documentation is available to support such a finding? (Certain lab tests define immunosuppression. Patients vary in their susceptibility to infections, depending on the severity and duration of immunosuppression.)
- General or ambiguous statements should be avoided.
  "Provider 'feels' community interaction would be a compromise to health." Why?
  "Frequent illness" Why? What is the cause or concern?
- If the child is on the Tech Dependent Waiver or Early Intervention Programs, the information MUST be included with each request.

E. Medical Supplies

Medical supplies for home health service are limited to the following:

1. Supplies used during the initial visit to establish the plan of care;

2. Supplies indicated by the physician in the approved plan of care.

Medical supplies provided by the home health agency on the initial visit do not require prior authorization. After the initial visit, medical supplies needed for patient care must be included in the plan of care.

Medical supplies included in the plan of care are subject to the coverage and prior authorization requirements and limitations of the Medical Supplies Program. For additional information about this program, refer to the Utah Medicaid Provider Manual for Medical Suppliers and the current Medical Supplies List.

F. I.V., Enteral, and Parenteral Therapy

I.V., Enteral and/or Parenteral therapy is covered as a home health service either in conjunction with skilled or maintenance care or as the only service provided. Specific policy is described in the Utah Medicaid Provider Manual for Medical Suppliers. Refer to the Utah Medicaid Provider Manual for Pharmacy Providers for information about enteral / parenteral therapy. Medical necessity and reasonableness must be established based on the appropriateness of administration in the home setting and the patient's condition and diagnosis.

4 - 4 Supportive Maintenance

This level of service is available to the patient with nursing care needs that have stabilized to the point that there are few significant changes occurring in the plan of care. The patient demonstrates limitations or significant disability which requires assistance with activities of daily living and could be totally bed bound or subject to nursing facility admission without the assistance. Care and service needs are based on physician orders and an approved plan of care, with review and recertification every 60 days.

4 - 5 Persons with Long Term Home Health Needs

A patient may be eligible for the long term capitated home health program when documented, diagnosed medical conditions require extensive services or substantial physical assistance with activities of daily living but little skilled care. When services required go beyond the cost-effective limit of usual home care, the Medicaid agency will conduct an analysis of the assessment and management of long term care needs.

The analysis is based on cost and the appropriateness of capitated home health service.

A. Cost Analysis

The cost of home health care must be equal to or less than the cost of care in an alternate setting such as a nursing facility. When Medicaid receives a prior authorization request for services which exceed the maximum allowable cost, staff notify the home health agency. The agency may be allowed to provide the requested services for 60 days. During the 60-day period, the agency must work with the patient, physician and family to determine the following:

1. Discharge Plan with the anticipated time the needs will continue.
2. Feasibility of alternate placement in a nursing facility on a temporary or permanent basis.
3. Physician assessment of care needs and the cost-effective requirements. (What alternate resources or therapy changes are possible to keep costs in line?).
4. Community alternatives, family accepting more care responsibilities etc., other resources that will safely bring the cost of care in line.
5. If cost of care cannot be brought into line, alternate placement in a nursing facility must be considered, or the agency can accept the capitated payment, or provide the patient with a 30-day written notice giving him time to secure another agency willing to provide the service under the cost-effective limitations.

B. Capitated Home Health Service

Capitated home health care provides service for clients such as paraplegics and quadriplegics who require little skilled care and need long term maintenance with activities of daily living, along with some other services, usually twice a day. Once a patient is approved for capitated home health care, the reimbursement is based on the cost of nursing facility care per day. The home health agency provides the required care to meet the patient's needs without billing for each service or visit.

Criteria considered by Medicaid Prior Authorization staff include:

1. Orders must be established by the physician and outlined in an approved plan of care.
2. Service needs are greater than six months.
3. Service needs require at least 120 aide visits in a consecutive 90 day periods.
4. Medical condition and intensity of service must be judged to be at the level that can be provided safely in the home setting.
5. Nursing intervention is required at least every two months to provide a skilled service.
6. Prior authorization is required for the capitated home health care program regardless of when the previous prior authorization was given. Medicaid may authorize services under this program for up to six months, or until there is a change in the patient's condition.
7. The home health agency must submit a new recertification request every 60 days.

NOTE: As with any other Plan of Care, any change in the patient's condition or care needs requires immediate evaluation and reconsideration of the service authorization.

As a reminder, all long term home health services require prior authorization. To keep the program cost effective, consultation between provider and Medicaid Prior Authorization staff is essential in determining approval of necessary services and use of appropriate codes.

Billing

Code T1022 is used for the capitated service, and represents a daily rate. No other home health services can be provided or billed when the client is receiving service under the capitated program.

A break in service coverage of four days or more must be discussed with the Medicaid Prior Authorization Unit Staff. When a break in service occurs, the provider must provide the necessary information so that an adjustment can be made to the authorization of service. When the client returns to Home Health Service, the provider must again contact the Medicaid reviewer to reopen the service.

4 - 6 Rural Area Home Health Travel Enhancement

Effective May 1, 2001, Medicaid will provide enhancements to the home health reimbursement rate when travel distances to provide service are extensive. The enhancement is available only in rural counties where round-trip travel distances from the care giver's base of operations are in excess of 50 miles. The client and the care giver must reside in the same or an adjacent rural county. Rural counties are defined as counties other than Weber, Davis, Salt Lake, and Utah counties. For round trip travel of 50 miles or more, the home health fee schedule will be multiplied by 1.75 to calculate the payment rate for applicable service codes.

Effective October 1, 2003, To receive the rural home health travel enhancement, home health agencies must file the claim using the applicable, approved service code listed in Chapter 6 with a modifier "TN". For example, code T1030 with a modifier "TN". For dates of service prior to October 1, 2003, a "22" modifier must be used with the applicable, approved service code.

Y0458 was used to provide the differential for San Juan. HIPAA requirements require closure of code Y0458. Beginning October 1, 2003, providers authorized for the San Juan differential must place the TN modifier on each line of the claim along with the appropriate home health care service code.

4 - 7 Telehealth Skilled Nurse Pilot Project for Patients in Rural Areas

Medicaid implemented a telehealth home care project effective January 1, 2000. The project is an additional, complimentary method to provide patient medical monitoring and education and to increase medical care compliance of home health care patients in rural areas. The project allows delivery of a percentage of home health care visits through Telehealth to patients who meet selection criteria. Criteria are: Patient lives in identified rural areas; meets diabetes eligibility requirements; is home bound and requires two or more home care nursing visits per week; and agrees to participate in Telehealth home care services. Refer to **Selection Criteria** below for details.

After one year, a cost benefit analysis will be completed to determine whether the project should continue. Any change to the program will be announced in a Medicaid Information Bulletin.

Definition of Telehealth

Telehealth or Telemedicine is a technological method of providing auditory and visual connection between the skilled home health care nurse at a Telehealth site and the patient living in a rural Utah area.

Authorized providers

All interested home health care agencies serving rural areas may participate in the pilot project. Home health care visits are authorized through utilization management, typically 10-12 visits are authorized. A percentage (20-30%) of skilled nurse home health care visits may be authorized for provision through Telehealth.

Selection Criteria

Diabetes patient eligible for participation in Telehealth must be able **to physically use** Telemedicine equipment including: ability to follow directions, push two colored buttons, hear and see, apply the blood pressure cuff or stethoscope appropriately, and **want to participate** in the Telehealth project. When the patient is unable to use Telemedicine equipment, the patient may be included in the pilot project if there is a full time care giver consistently available who wishes to assist the patient with Telehealth.

Diabetes patient condition indicates to prior authorization staff that hands on assessment is probably not required, and/or the home health care nurse determines that the patient does not meet severity of illness or have complicating conditions which might limit patient inclusion in the study. The appropriateness of delivering adequate education and/or monitoring will depend on the equipment available. The **skilled nurse must determine if patient care needs and quality of care delivery** will be met through the use of the Telehealth mode of delivery.

Covered Services

After Utilization Management preauthorization, the following services are covered for Telehealth home care patients:

- monitoring for compliance in taking medications, foot condition/assessment of wounds or inflamed areas, blood glucose monitoring
- education which may include a review in knowledge of the disease process, diet or nutritional counseling, exercise and activity, diet /activity adjustment in illness/stress, medication, and glucometer use evaluation.

Home health care has a four-hour limit for all education purposes, which may include some diabetes training.

Limitations

- HCFA rules for Medicaid/Medicare do not allow reimbursement for Telemedicine equipment or Telemedicine transmission costs.
- The State would not anticipate a bill nor approve payment for a patient initiated anxiety call to the home health agency. Spot checks related to patient anxiety calls are not considered a home health care visit by Utah Medicaid.
- Medicaid eligibility for home health care is limited to home bound patients. Home bound status must be documented by the home health agency. Telehealth home care visits are limited to patients living in rural areas of Utah. Patients residing on the Wasatch Front are not eligible for inclusion in the study. Wasatch front patients have access to home health care through their HMO provider.
- The State would not expect Telehealth home care to become the exclusive means of delivering home health care; it is viewed as an enhancement to traditional home health care for rural or remote areas of Utah.
- RN visits are covered for Telehealth home care reimbursement.
- The home health agency will provide home health agency staff with extensive training and practice in how to use Telehealth technology. The Telehealth participating patients will receive an explanation of the purpose of Telehealth home care, adequate training in the use of Telehealth equipment and will sign a consent to participate in Telehealth. Medicaid will not reimburse for home health agency staff or patient training in Telehealth equipment use.
- The home health care nurse and the participating home health agency will address staff and patient concerns about privacy and confidentiality.
- The state requires the patient have a desire to participate in the home health care project. The home health agency must not discriminate against patients who do not wish to participate in Telehealth home care.

Billing and Payment

Bill on a HCFA 1500 Claim Form.
No payments will be made for Telehealth transmission expense or facility charge.
Reimbursement for Telehealth home care visits will be discounted from the charge for the home health visit delivered by traditional methods.

Codes The following code changes are required due to HIPAA requirements:

T1002 15 minutes or one unit of Telehealth home care RN time, limit 2 units per date of service

S9470 30 minutes of Telehealth home care dietary counseling provided by a registered dietician. The modifiers GT and TG must be submitted with the code S9470 for this service.

Modifiers

Covered
GT - Each skilled nurse Telehealth home care visit must indicate the service was provided through Telehealth by adding the GT modifier. This modifier is required to monitor and evaluate the financial impact of this project.

Non-Covered
GQ – telehealth data via asynchoronous telecommunications systems is the code used for transmission of telehealth data such as radiology or electrocardiogram. This is not a covered service for the Medicaid Telehealth home health care project.

5 PRIOR AUTHORIZATION

The home health agency must submit a plan of care and request prior authorization for all home health services beyond the initial visit, including therapies. Approval must be received before additional services are given. The level of service, skilled or maintenance, is established and approved based on the prior authorization request.

- When the level of service needs to be changed, the home health agency must submit a new request for prior authorization.
- For patients with an approved Plan of Care, a new prior approval request must be submitted upon the required recertification date (every 60 days).
- Prior authorizations for home health services are provider specific. This means that only the agency that applied for and received the prior authorization may use the authorization number. If another agency assumes responsibility for serving the patient, that agency must apply for and receive a separate prior authorization.

The process to obtain prior authorization is described below.

A. When the initial nursing assessment indicates a Medicaid recipient may qualify for home health services, we would like the request for prior authorization submitted immediately following the nursing assessment. However, for prior authorization consideration, the request for prior authorization must be requested by fax within two business days of the nursing assessment.

Medicaid Information:

In the Salt Lake City area, call **538-6155**
Call toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado **1-800-662-9651**

Follow the telephone menu prompts to reach the Prior Authorization staff for home health services.

B. Medicaid will review the request and documentation. Approval may be given for up to sixty days, unless the Plan of Care indicates a shorter time is required for home health care. For complete information about the Prior Approval process, please refer to SECTION 1 of this manual, Chapter 9, PRIOR AUTHORIZATION PROCESS. SECTION 1 is available on the Internet at http://health.utah.gov/medicaid/pdfs/SECTION1.pdf

Send written requests to:

MEDICAID PRIOR AUTHORIZATION
BOX 143103
SALT LAKE CITY UT 84114-2904

or Fax to **(801) 538-6382** attention "Prior Authorizations"

6 HOME HEALTH PROCEDURE CODES

Type of Service **Page**

EXPLANATION OF TABLE

Billing codes for the Medicaid Home Health Program are listed in this chapter. The list is updated by Medicaid Information Bulletins until republished in its entirety. Below is an explanation of each column and codes on the table.

CODE This is the assigned **HCPCS** code for the home health service.

DESCRIPTION This is the description used by Medicaid to identify the code.

PA **P**rior **A**uthorization is required by Medicaid when either of the following codes is entered in this column.
T - Telephone Prior Authorization
W - Written Prior Authorization.

Prior Authorization is NOT required when the letter **N** is in the PA column.

CRITERIA Specific information and criteria required by Medicaid before the service will be reimbursed.

LIMIT Indicates the allowable number of times the service may be reimbursed within the given time frame.

KEY TO DISTINGUISHING CODE CHANGES:

New codes are in **bold print**.

A vertical line in the margin, like the example to the left, marks where text was changed or added.

An asterisk (*) in the margin marks where a code was deleted with no replacement code.

HOME HEALTH AGENCY PROCEDURE CODES

- **There is no age limitation for home health care.**
- **Medical necessity only, no social needs, no respite care.**
- **Observation and assessment must be accompanied by hands on care.**
- **The home must be the most appropriate setting consistent with the client's medical need.**
- **Severity of illness and intensity of service must be met for all home health service.**

R.N. ASSESSMENT

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
T1001	Assessment/evaluation visit in the home by R.N. to establish care plan and medical necessity.	N	Referral by physician	one per admission

PRN VISITS

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
S9123	Nursing care in the home by RN, General Nursing Care Only, (For and emergency), per Visit	W	1. Currently on Home Health Service 2. Unscheduled emergency visits 3. Physician orders are required	2 visits /30 days

MEDICAL SUPPLIES

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
T1999	Miscellaneous therapeutic (medical) items and supplies for use in the home	N	1. Non-durable equipment or supplies used during initial visit to establish plan of care. 2. Supplies consistent with approved plan of care. 3. Specific items must be identified.	1 unit per client Initial visit only

HOME HEALTH SKILLED NURSING

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
T1030	Nursing care in the home (R.N.), per day	T first 30 days only W For continued care	Must meet the following: 1. Severity of illness and intensity of service must be such that the level of skill required can only be provided by a licensed RN or LPN. 2. Care needs must be based on physician order and plan of care and recertified every 60 days. 3. Special adaptive or assistive equipment is required 4. Ability to function outside of the home is severely limited by medical need including the need for special assistance	. Daily visits limited to 21 Visit = 2 hours maximum per day . Teaching limited to 4 visits . May visit 2 times per day (one hour maximum each) for maximum of 21 visits (11 Days)
T 1030	Nursing care in the home (RN) per day Antepartum/Postpartum home visit ☆See note at bottom of IV therapy code list for hydration therapy for pregnant woman.	Same as above	There is or has been a high risk pregnancy or delivery and there is indication of some specific medical need to be addressed or evaluated. Significant medical problems exist as a result of high risk pregnancy or delivery or prematurity. Must not be based on convenience. Condition must be such that patient cannot travel to the physician office for necessary evaluation. The home must have been established as the most appropriate, cost effective setting for this service.	Same as above
T1031	Nursing care in the home, Licensed Practical Nurse (LPN), per day	Same	As above	Visit = 2 hours maximum per day

SKILLED HOME HEALTH AIDE

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
T1021	Home Health Aide service in the home , per visit	T First 30 days	Must meet the following: 1. Severity of illness and intensity of service must be such that the skills of a home health aide can meet the need on a consistent basis. 2. Ability to function outside the home is severely limited by medical need including the need for physical assistance 3. Care needs must be such that they can be met by a certified nurse aide with an appropriate skill level 4. Care provided must be under the written direction of the supervising RN 5. May authorize 2 times per day for clients needing extensive assistance on a temporary basis to meet a short term special need.	. One visit/ day Visit = 2 hours . May visit same day as nurse (RN or LPN who provides only a brief service at a skill level that cannot be provided by the Aide. Nurse would provide a service through use of code T1003, T1002, or Q0018.) ☆ See Note

☆NOTE: When two patients in the home are receiving services, care needs will be evaluated as a total package. Service Units will be adjusted and authorized as a total package. Two aides will not be approved for service except under extreme circumstances or changing care needs requiring additional service by individual care givers. Duplicate payment will not be approved under any circumstances if only one care giver goes to the home and provides the total units of care for both patients.

SUPPORTIVE MAINTENANCE - REGISTERED NURSE

- Physician referral – Cases are stabilized; no significant changes are occurring in plan of care or physician orders.
- Significant disability requiring minimal assistance is present.
- Would be totally bed bound and/or restricted to home without assistance with ADL's

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
T1001	Nursing Assessment and Evaluation Comprehensive Level of Service R.N. Only Recertification visit	W	1. Plan of care implementation and revision as necessary 2. Coordination of all services 3. Initiation of preventive and rehabilitative nursing procedures 4. Consultation regarding patient changes in condition (staff and physician) 5. Prepare and record clinical progress notes 6. Supervise care given by LPN or Aide (Not a separate billable service) 7. Supervise and teach other nursing personnel 8. Reevaluation of patient's nursing care needs every 60 days as required by federal regulation.	. One billable visit every 60 days. But must visit as often as necessary to meet agency supervisory responsibility . Visit = 2 hours . May not visit same day as home health aide.

SUPPORTIVE MAINTENANCE - NURSE

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
T1003	Licensed Practical Nurse (LPN) visit in the home, per visit	T First 30 days W for continued service	Care and service needs requiring time and skill with allowance for observation of the results of any treatment, and evaluation and determination of changes in service needs to be reported. Examples, but not limited to: • Daily insulin injection only if patient is physically not capable to learn or administer own injection or there is no other care giver in the home. • Insulin syringe prefills for a patient who gives own injections. • Injections as ordered by physician or administration of other medications which patient cannot administer independently. • Pre-fill oral medication boxes • Simple dressings on chronic, non-draining wounds. • Minimal teaching regarding routine care and adaptive measures for diabetic patients, cardiac patients, and patients with urinary and bowel dysfunctions. • Colostomy care - with irrigation. • Assistance with ADLs such as quadriplegia care.	One visit per day May visit same day as a home health aide for special services aide can not provide. Limits apply
☆ T1003 Continued	Medications: Some medications may be ordered BID to be given by a nurse (RN or LPN), (Lovenox is an example). Dressing Changes: May be ordered BID Blood draws are occasionally necessary when a patient cannot go out to a laboratory. (RN or LPN)	T T	Physician must provide orders for number and frequency of injections. A care giver in the home or the patient should be taught to administer the injections when ever possible. Specific orders for number and frequency must be provided. Care givers should be taught if possible. Specific physician orders are necessary. Some orders may be for BID (Peak and Trough) where timing is precise. Inability to leave the home should be medically necessary and verified. This should not be for convenience.	

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
S9124	Nursing Care in the home (General Nursing Care) by Licensed Practical Nurse (LPN), per visit	T First 30 days W For continued service	Care and Service needs requiring extensive contact to provide direct care, including all of the services noted above plus retraining in self-help skills for activities of daily living, and observation, recording and reporting changes in condition to supervising RN.	One visit / day May not visit same day as a home health aide.
G0154	Services of skilled nurse in home health setting, per visit	T First 30 days W for continued service	Care and service needs requiring time and skill with allowance for observation of the results of any treatment, and evaluation and determination of changes in service needs to be reported. Examples, but not limited to: • Daily insulin injection only if patient is physically not capable to learn or administer own injection or there is no other care giver in the home. • Insulin syringe prefills for a patient who gives own injections. • Injections as ordered by physician or administration of other medications which patient cannot administer independently. • Pre-fill oral medication boxes • Simple dressings on chronic, non-draining wounds. • Minimal teaching regarding routine care and adaptive measures for diabetic patients, cardiac patients, and patients with urinary and bowel dysfunctions. • Colostomy care - with irrigation. • Assistance with ADLs such as quadriplegia care.	One visit per day May visit same day as a home health aide for special services aide can not provide. Limits apply

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
☆ G0154 Continued	Medications: Some medications may be ordered BID to be given by a nurse (RN or LPN), (Lovenox is an example).	T	Physician must provide orders for number and frequency of injections. A care giver in the home or the patient should be taught to administer the injections when ever possible.	
	Dressing Changes: May be ordered BID	T	Specific orders for number and frequency must be provided. Care givers should be taught if possible.	
	Blood draws are occasionally necessary when a patient cannot go out to a laboratory. (RN or LPN)		Specific physician orders are necessary. Some orders may be for BID (Peak and Trough) where timing is precise. Inability to leave the home should be medically necessary and verified. This should not be for convenience.	

SUPPORTIVE MAINTENANCE - HOME HEALTH AIDE

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
T1021	Home Health Aide Service, in the home, per visit (Same as Skilled Aide Service)	T First 30 days W For continuing service	For patients whose care needs have stabilized, but still have a need for general nursing care, and there are care-givers in the home. The same criteria as for any home health visit must be met - Physicians order, plan of care, and detailed orders. Written instructions to be followed by the aide must be provided by the supervising nurse . In addition, an assessment must document medical necessity and how much help is available from the family to supplement the agency assistance. Support and assistance from family members is essential in order to maintain home health service for some clients at a level that is realistically appropriate and cost effective. Family members who have physical and/or medical limitations which could affect their ability to participate in supplementing agency services can provide a statement from their primary care physician identifying the limitations. The medical statement(s) will be considered in the evaluation of care needs.	One visit per day Visit = 2 hours May visit the same day as a nurse (RN or LPN who provides only a brief service at a skill level an Aide cannot provide. Service would be one the nurse would provide using code T1003, T1002, or Q0018)
S9122	Home Health Aide Service in the home, per hour Extended Level of Service	T First 30 days only W For continued service	Patient lives in an independent living situation with no care giver to assist. 1. Care needs have stabilized to the point that few significant changes are occurring in the plan of care. 2. Client requires assistance with activities of daily living to prevent bed confinement or nursing home admission. 3. Plan of care needs must be based on physician orders and an approved plan of care with review and recertification every 60 days. 4. May authorize 2 times per day for clients needing extensive assistance getting into bed at night, and out of bed in the morning. ☆	1 unit = 1 hour up to a maximum or 4 per day

LONG TERM HOME HEALTH CARE

Text removed January 2004

HOME HEALTH IV THERAPY

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
T1002	RN Services, Per visit. (For I.V. or parenteral therapy in the home)	T first 30 days W For continued service	1. I.V. placement or demonstration to care giver concerning reinforcement of hospital cleaning instructions 2. Current diagnosis requiring IV therapy must meet criteria for home health nursing.	Procedure code may be billed for initial placement, or for an emergency, or for dressing changes or blood draws as noted below.
Q0081	Infusion Therapy, per visit R.N. follow up visit to: . Administer I.V. therapy . Teach care giver administration of IV. therapy To reinforce hospital instruction related to IV. therapy or administration of IV medications and/or fluids, or parenteral therapy, catheter care, catheter dressing changes, discontinue the IV. or remove the catheter.	T first 30 days only W for continued service	1. Specific physician order, as to quantity, frequency, duration and substance to be infused, must be in approved plan of care. 2. Medical necessity and reasonableness must be established based on the appropriateness of administration in the home setting and the patient's condition and diagnosis. 3. Client, care giver, and/or other responsible adult in the home must be willing and able to learn related administration observation and techniques.	Visit = up to 2 hours Up to 4 times a day may be approved in unusual situations for a limited time
T1002	Nursing service related to home IV Therapy (RN), per visit Catheter Care and Dressing Change. (Time should be limited to minimal visit, under one hour, for these services.)	T first 30 days only W For continued service	1. Client on I.V. Therapy 2. Central line, PIC line, subclavian lines etc., which require dressing changes client or care giver unable to perform. 3. Blood draws associated with infusion therapy should be drawn by the RN at this visit.	. One per week for routine dressing changes . Two times a week if patient is high risk for infection. . Not applicable for enteral therapy.

NOTE: Hydration therapy may be approved for a pregnant woman when medically necessary due to hyperemesis or other defined complications of the pregnancy. Service must be based on physician order and prior authorization. This service extends to women on the "Baby Your Baby" program and to those on regular Medicaid.

HOME HEALTH PHYSICAL THERAPY

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
S9131	Physical Therapy in the home, per day (Evaluation)	Y (Include in number of visits authorized)	1. Client must meet criteria – not age limited 2. Referral by physician 3. Initial Home Health assessment must have been completed by the nurse prior to or at the same time as the P.T. evaluation. 4. PT must be part of the plan of care. 5. The goal of home based physical therapy service must be to move the patient to independence and self sufficiency and the ability to move beyond home based service to the care of community providers.	One per admission
S9131	Physical Therapy in the home, per day (Direct Care)	T First 30 days W For continued service	The following conditions must be met: 1. Physician order must identify amount, duration and frequency of treatment. 2. The patient's condition must be such that services required can be safely and effectively performed in the home by a licensed physical therapist. 3. Physical therapy must relate directly and specifically to a written treatment order by the physician and must be reasonable and necessary to the treatment of the patient's current individual illness or injury. 4. There must be an expectation that the condition will improve significantly in a reasonable period of time. 5. Service cannot be continued if there is no documentation of improvement.	Visit = up to 2 hours Skilled service 3-4 times per week determined by orders and plan review. Clients approved for supportive maintenance level of care 1-2 times per week

PHYSICAL THERAPY IN THE HOME – MAINTENANCE

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
G0151	Physical Therapy in the home, each 15 minutes (Maintenance)	Written	Patient has been on regular physical therapy. Physician orders Plan of Care Needs/goals documented Review and demonstration with parents for the role they play in supporting and sustaining therapy in the home. Parents must be working with the child on a program at home Note: Maintenance or palliative care is basically a non-covered service, approved only in unusual circumstances of medical necessity, to be determined by the Medicaid nurse reviewer, to check compliance of patient and care givers with home therapy program established by the therapist for the patient.	By review

OCCUPATIONAL THERAPY IN THE HOME

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
S9129	(On Hold)	written	See SECTION 2, page 14	

NOTE: OCCUPATIONAL THERAPY IN THE HOME IS A NON-COVERED SERVICE THROUGH HOME HEALTH, REQUESTS CAN BE MADE THROUGH THE CHEC PROGRAM FOR REVIEW BY THE CHEC COMMITTEE.

HOME HEALTH SPEECH - LANGUAGE THERAPY

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
S9128	Speech therapy in the home, per day Evaluation of speech/language for medical necessity of Home Health Speech Therapy	Y Include in number of visits authorized	1. Referral by physician 2. The initial Home Health assessment must have been completed by the nurse prior to or at the same time as the speech evaluation.	One visit per admit.
S9128	Speech Therapy in the Home, per day (Direct Therapy) The home must be the most cost effective and appropriate setting for the service.	T First 30 days only W For continued service	The following conditions must be met: 1. Physician order identifying amount, duration and frequency of treatment 2. The patient's condition must be such that services required can be safely and effectively performed by a licensed speech therapist. 3. Speech therapy must relate directly and specifically to a written treatment order by the physician and must be reasonable and necessary to the treatment of the patient's current individual illness or injury. 4.There must be an expectation that the condition will improve significantly in a reasonable period of time. 5. Services cannot continue if there is no documentation of improvement.	Skilled service 3-4 times per week (Maximum Number of visits)
G0153	Services of speech and language pathologist in home setting, each 15 minutes (Maintenance)	Yes	Patient must have been receiving speech therapy, moving to maintenance. Physician Order Plan of care Skills/goals identified Review and demonstrate to parents the role they play in supporting and sustaining therapy in the home Parents must be working with child in a program in the home	By review

ANTEPARTUM/POSTPARTUM HOME HEALTH SERVICES

Text removed January 2004

See code T1030

HOME HEALTH SERVICES TO PERSONS WITH MENTAL ILLNESS

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
S9485 Crisis intervention mental health services, per hour. S9480 Intensive outpatient psychiatric services, per day	Home Health service may be appropriate in some instances for treatment of psychiatric disorders. Medicaid will reimburse psychiatric health care when all requirements of skilled nursing are met and, in addition, the criteria of this section are met.	T First 30 days only W For continued service	1. Client must not be in a capitated mental health program 2. In order to provide medically necessary and appropriate home health services to a psychiatric patient, the agency must employ a registered nurse with the necessary training, skills and experience. (Documentation of advanced training and specialty in psychiatric nursing or LCSW must be provided to the agency.) 3. Care and service to a patient suffering from a diagnosed psychiatric disorder require the skills of a nurse who has special training and/or experience beyond the standard curriculum required for the registered nurse (RN). Examples of such special training or experience include a Masters' Degree in Psychiatric or Mental Health Nursing or equivalent training, experience as a member of the nursing staff in an active treatment unit of a psychiatric hospital. This special training enables the nurse to interpret a patient's behavior and actions and to know when it is appropriate to seek physician intervention to alter the plan of care. 4. An individual whose psychiatric disorder is severe enough to require the skills of a psychiatric nurse must be under the care of a physician (preferably a psychiatrist). The plan of care calling for the services of a psychiatric nurse will be established and reviewed by the physician. 5. Service to a patient with a mental disorder must meet the following criteria: A. Patient's diagnosis code must be in ICD.9.CM within the range of 290 - 317. B. Medical necessity as previously noted must be demonstrated.	2 hours Maximum one visit per day Visit = 2 hours

PRIVATE DUTY NURSING

CODE	DESCRIPTION- DIAGNOSES	PA	CRITERIA	LIMIT
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes 1 Unit = 15 minutes 4 Units = 1 hour 96 Units = 24 hours ☆ Coding: T1000 is the main code RN Service to use T1000 to pay at $8.00 per 15 minutes LPN Service to use T1000-TE to pay at 78% of the fee schedule – $6.24 per 15 minutes Payable to: Home Health Agency – Maximum 96 Units/day to begin Decreased to a maximum of 32Units/day (8 hours) as appropriate	Y	Private Duty Nursing is an optional service included under the umbrella of Home Health Service. Patient must be CHEC eligible and under the age of 21 years. Require the routine use of a ventilator or tracheostomy to compensate for the loss of a life sustaining body function. Require daily, ongoing care or monitoring at a skill level that can only be provided by a registered nurse or licensed practical nurse. Service must be consistent with the nature and severity of the illness, injury, or unique medical condition, and the accepted standards of medical and nursing practice. Parent, guardian or primary care giver must be willing to learn, and trained to learn, tasks necessary to provide a safe environment and quality care in the home for a number of hours during times nurse is not present. Services must be based on physician's written orders, documented skills required for level of care and the time involved in performing those skills (time study), written plan of nursing care, commitment by a home health nursing agency to supply the appropriate nursing services, and the care givers commitment to learning necessary skills.	Maximum of 24 hours for a limited period of time - (1-2 weeks) Maximum hours will be reduced every 1-2 weeks as the home setting is established and organized until a level of 8 hours has been reached. ☆ See Note

☆Note: When two patients in the home are receiving services, care needs will be evaluated as a total package based on physician orders and time study. Service units will be adjusted and authorized as a total package. Two nurses will not be approved for service except under extreme circumstances and new critical care needs requiring additional service by individual care givers. Duplicate payment will not be approved under any circumstances if only one care giver goes to the home and provides the total units of care for both patients. Effective April 1, 2006, a differential payment will be provided to the private duty nursing service when the total units of care apply to more than one patient. For differential reimbursement, submit the UN modifier on the claim to indicate care was provided for more than one patient.

See Major protocol for details and explanations of the Private Duty Nursing program.

INDEX